

## Report of Glucagon Administration

Please mail or fax form to: State School Nurse Consultant  
Four Capitol Mall, Slot #14, Little Rock, AR 72201 Fax: 501-683-3586

School District/Campus \_\_\_\_\_

Student/Staff Member Age: \_\_\_\_\_ Gender: \_\_\_M \_\_\_F Incident Date \_\_\_\_\_

Time/Place of occurrence: \_\_\_\_\_

Symptoms (if observed): \_\_\_\_\_

Location of person when symptoms developed: \_\_\_\_\_

Location of person when Glucagon administered: \_\_\_\_\_

Location of Glucagon storage: \_\_\_\_\_ Is it in a locked cabinet? \_\_\_Yes \_\_\_No

Glucagon administered by: \_\_\_RN \_\_\_LPN \_\_\_Unlicensed Assistive Personnel

If other than an RN, was this person formally trained? \_\_\_Yes \_\_\_No Date of training: \_\_\_\_\_

If Yes, who provided this training? \_\_\_\_\_ Curriculum used: \_\_\_\_\_

Previous history of Glucagon use: \_\_\_Yes \_\_\_No \_\_\_Unknown

Approximate time between onset of symptoms and administration of Glucagon: \_\_\_\_\_minutes

Emergency Health Care Plan (IHP) in place? \_\_\_Yes \_\_\_No

Physician notified? \_\_\_Yes \_\_\_No Parent/guardian called? \_\_\_Yes \_\_\_No

### Disposition:

Transferred to ER? \_\_\_Yes \_\_\_No Discharged after \_\_\_\_\_hours.

Hospitalized? \_\_\_Yes \_\_\_No Discharged after \_\_\_\_\_days.

Sent to private provider? \_\_\_Yes \_\_\_No

Student/Staff outcome: \_\_\_\_\_

Debriefing meeting held at school? \_\_\_Yes \_\_\_No

Form completed by: \_\_\_\_\_ Date: \_\_\_\_\_

(please print)

Title: \_\_\_\_\_ Phone #: (\_\_\_\_) \_\_\_\_\_ Ext: \_\_\_\_\_

School Address: \_\_\_\_\_

Email Address: \_\_\_\_\_ Fax number: (\_\_\_\_) \_\_\_\_\_